DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27566

FILED SEP 12 1941

Registration District No. 2119

Primary Registration District No. 1002

Registrar's No. 3824

WHITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1. PLACE OF DEATH:
(a) County Jackson
(b) City or town Kansas City (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 3119 Tracy (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 1 (Specify whether
In this community years, months or days) 35 Yrs (Jan 41)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Jackson
(c) City or town Kansas City (If outside city or town limits, write "RURAL")
(d) Street No. 3119 Tracy (If rural, give location)
(e) If foreign born, how long in U. S. A.? No years.

3. (a) PRINT FULL NAME Sarah Frances Godsey Effle
3. (b) If veteran, name war No
3. (c) Social Security No. No

4. Sex Female
5. Color or race White
6. (a) Single, widowed, married, divorced Divorced
6. (b) Name of husband or wife Henry Effle
6. (c) Age of husband or wife if alive 75 years
7. Birth date of deceased July (Month) 19 (Day) 1866 (Year)

8. AGE: Years 75 Months 1 Days 6 If less than one day ✓ hr. ✓ min.

9. Birthplace Indiana (City, town, or county) (State or foreign country)
10. Usual occupation Retired
11. Industry or business

MOTHER FATHER
12. Name Norman Nelsey
13. Birthplace Unk (City, town, or county) (State or foreign country)
14. Maiden name Belle Jennings
15. Birthplace Illinois (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Mrs Sadie Sawyer
(b) Address 3119 Tracy
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof Aug-27-41 (Month) (Day) (Year)
(c) Place: burial or cremation Carrollton Mo
18. (a) Signature of funeral director A. P. Doehler
(b) Address 1415 East 15 St KC Mo
19. (a) 8/27/41 (Date received local registrar) (b) M. M. Crow (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Aug day 25 year 1941 hour 29 minute 45 P M.
21. I hereby certify that I attended the deceased from June 20, 1941, to Aug 25, 1941; that I last saw h alive on 8/23/, 1941; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: Cardiac Failure	
Due to: Chronic Myocarditis & Cardiac Hypertrophy	
Due to: Chronic Nephritis	
Other conditions: Bronchitis (Include pregnancy within 3 months of death)	

Major findings: Of operations 1315
Of autopsy no

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature D Dillman (M. D. or other) MD
Address 10307 Indp ave Date signed 8/26/41

(Licensed Embalmer's Statement on Reverse Side)

Ind. 4018 - Ind. 4032.
St. Joseph Hospital

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed H P Doehler

Licensed Embalmer No. 1166

P. O. Address 1415 East 15

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.